Proceedings of The National Conference
On Undergraduate Research (NCUR) 2018
University of Central Oklahoma
Edmond, Oklahoma
April 5-7, 2018

Historical Trauma in Native American Communities: Implications, Interventions, and Clinical Considerations

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Abstract

Health disparities in native communities today are undoubtedly related to historical trauma, which is described as the wounding of generations due to traumatic experiences such as boarding schools, forced displacement, and genocide. Responses to this distress manifest in various social issues including abuse, depression, domestic violence, and suicide. A comprehensive understanding of historical trauma is required to understand the current state of these communities. As this transcends generations, the prevalence of adverse childhood experiences (ACEs) in Native American populations is important to consider and can be viewed as an indication of historical trauma. ACEs refer to traumatic events that occur during childhood, such as abuse and neglect, and include 9 conditions. To measure an ACE score, one point is counted for each condition experienced. In Minnesota, it was found that 27% of Native Americans report high (five or more) ACE scores, whereas only 7% reported this in the white population. Additionally, health conditions that are pervasive in native communities, such as depression, anxiety, diabetes, and obesity, are all positively correlated with ACE scores. While these disparities are extensively documented, they are not truly addressed in the clinical setting. However, the possibility of using mind-body healing - a holistic approach that emphasizes the interconnection of the mind, body, and spirit - is promising. The Center for Mind-Body Medicine (CMBM) provides the largest program in the world to train others in mind-body medicine techniques and directly addresses population-wide trauma in their model. Furthermore, the CMBM notably aims to promote healing within the community rather than dictating this process as an outside force. Their model is designed to allow these techniques to be integrated into the cultural healing traditions of communities. This project investigates the impacts of historical trauma, current interventions, and clinical considerations.

Keywords: Historical trauma, Adverse Childhood Experiences, Native American health

1. Terms and Concepts

Historical trauma is a concept that is described as the wounding of generations of indigenous people due to traumatic experiences such as boarding schools, forced displacement, loss of land, and genocide. What makes these events particularly disturbing is that they were caused by human beings as opposed to resulting from environmental disasters or accidents. These traumatic experiences are considered to have had compounding effects as they occurred across generations and continue to have an impact on individuals and communities today.

Historical trauma response is a set of characteristics observed in those who have experienced substantial collective trauma as well as their descendants. Responses to this distress manifest as numerous social issues, including child abuse, sexual abuse, depression, domestic violence, and suicide.

Historical unresolved grief refers to the prolonged mourning throughout generations that results from a disrupted grieving process. Brave Heart[2] coined this term in her article "The American Indian Holocaust" to describe this concept. In this context, the dominant society has deemed the grief from these traumatic events invalid by prohibiting the traditional grieving practices of indigenous communities. Consequently, the healing process was inhibited and mourning was not completed. Symptoms of this differ from usual grieving responses in the respect that they are more severe, persist for extended periods of time, and is transferred across generations.

Adverse childhood experiences, commonly referred to as ACEs, can be viewed as an indication of historical trauma. According to the Minnesota Department of Health[1], ACEs are defined as traumatic events that occur during childhood and include nine conditions: physical abuse, sexual abuse, emotional abuse, family history of mental illness, alcoholism in the household, illegal drug use in the household, divorce or separation of parents, domestic violence in the household, and incarceration of a family or household member. To measure an individual's ACE score, one point counts for each condition that was experienced throughout childhood.

2. Understanding Historical Trauma

Knowledge of the causes and effects of historical trauma is imperative to truly understand the current state of afflicted communities today. Compared to the non-Hispanic white population, Native Americans and Alaska Natives have greater infant mortality rates, are twice as likely to die of sudden infant death syndrome (SIDS), 90% more likely to become obese as a preschooler, and twice as likely to attempt suicide in high school. Furthermore, in adulthood individuals are twice as likely to die from liver disease and have a 90% greater chance of dying from diabetes[10]There are also numerous barriers to accessing quality healthcare–roughly 26% live at poverty level and almost 23% percent do not have health insurance. These adverse statistics are not simply by chance; these negative medical and social outcomes are community-wide and connected to historical trauma.

Evans-Campbell[9] provides a framework for understanding historical trauma in Native American communities, which consists of three levels: individual-level impacts, family-level impacts, and community-level impacts. Individual-level impacts of historical trauma have been analyzed in detail, especially in victims of the Holocaust. Although many survivors exhibited incredible resilience, they clearly displayed a variety of psychological issues, including anxiety, depression, denial, sleep disturbances, and survivor's guilt. These symptoms, also seen in other populations affected by historical trauma, were collectively termed "survivor's syndrome" by researchers and are now included in the diagnostic criteria for post-traumatic stress disorder (PTSD).

The descendants of these survivors revealed higher rates of the some of the symptoms in the "survivor syndrome" that their relatives experienced. Evans-Campbell[9] discusses a study in her article "Historical Trauma in American Indian/Native Alaska Communities" which determined that after experiencing several stressful events, children of Holocaust survivors indicated a greater risk of developing PTSD or related symptoms compared to the general population. In a study on two large Native American reservations, Whitbeck et al.[16] observed that the characteristics that comprise the historical trauma response as well as unresolved grief continued to be regularly experienced in individuals even several generations following the occurrence of traumatic events.

Unlike individual effects, the impacts at the family-level reveal manifestations of historical trauma are subtle and not obviously recognizable. Research on Holocaust survivors determined two central trends that interfere with interactions between parents and children. One is the efforts of children to prevent causing further distress in their parents' lives by avoiding discussion about these traumatic events. Additionally, feelings of guilt caused children to devalue their personal issues in contrast to those endured by their parents. This comparison similarly impacts children's perception of their happiness, a right that many others were deprived of. Both of these trends are likewise seen in Native American communities.

The impacts at the community-level are, according to Evans-Campbell[9], the most detrimental and misunderstood in this framework. While this seems obvious, as illustrated by the unfavorable health and social statistics reviewed earlier, effects on the community are not usually mentioned when examining the impacts of traumatic events. For instance, research on the effects of boarding schools largely emphasizes the psychological and behavioral consequences of individual survivors. Yet, this is merely a single facet of the complete context of consequences arising from boarding schools; they notoriously targeted children with the intention of eradicating indigenous languages, traditions, identities, and communities. Evans-Campbell[9] suggests that historical trauma is transmitted through these familial interactions such as compromised parenting styles, in addition to societal influences including the loss of traditional values. This lack of communication regarding traumatic events–from avoidance and silence of

affected individuals as well as the ignorance of society at large–significantly hinders the ability of affected communities to heal from these experiences.

Manifestations of historical trauma such as alcoholism and substance abuse could be perceived as attempts to numb unresolved grief. The manifestations of historical trauma in the form of abuse is illustrated in the doctoral dissertation of Dylan Galos[11], who employed epidemiological data analysis to investigate intergenerational child maltreatment. While there is no explicit discussion of historical trauma or specifically focus on native populations, the probability of intergenerational transmission was found to be the highest among the Native American population. Additionally, it was noted that those who endured multiple forms of maltreatment display high rates of intergenerational transmission, which suggests a multidimensional impact of maltreatment on development.

3. Measuring Historical Trauma

Quantitative measurement of historical trauma will not only provide evidence of the historical trauma theory but could be used in research to investigate the prevalence of historical trauma as well as assess the effectiveness of interventions. Whitbeck et al.[16] developed two empirical measures of historical trauma: The Historical Loss Scale and The Historical Loss Associated Symptoms Scale. The Historical Loss Scale determines the kinds of losses associated with historical trauma, including land, language, and culture as well as family disruption due to boarding schools and relocation. The Historical Loss Associated Symptoms Scale identifies emotions experienced due to these losses, such as anger, shame, isolation, and mistrust. This is a noteworthy contribution to the field as it is the first step in providing evidence for the historical trauma theory and quantitative investigation of the prevalence of historical trauma and contemporary consequences. Wiechelt et al.[14] used these measures in their study of historical trauma in an urban native population following a disease prevention program.

However, Whitbeck et al.[16] noted that a significant drawback is the lack of severity levels in both scales for reported symptoms and feelings. Additionally, the extent to which results of these scales can be generalized among the entire Native American population is largely unknown. Wiechelt et al.[14] also contemplates this concern when discussing the fact that groups differ in responses depending on their experiences, since not all Native American groups experienced the exact same traumatic events. In consideration of this they realized that responses to historical trauma are more complex than was initially thought, and thus concluded that the results of their study "barely scratched the surface" of historical trauma.

Brave Heart et al.[2] notes that although there may be variations in the severity of trauma experienced between groups, they nonetheless share the experience of enduring traumatic events. They believe that further research on interventions should primarily focus on producing treatment models that can easily alter to different groups. Brave Heart et al.[2] proposed a possible solution as the Indigenous Peoples of the Americas Survey (IPS), which is a measure that intentionally considers individual trauma as well as unresolved grief and consolidates assessments for psychiatric symptoms, detailed trauma histories, and indigenous identity. Aspects of the Historical Loss Scale and the Historical Loss Associated Symptoms Scale are utilized, but the IPS requires a more comprehensive report on both individual trauma history as well as the collective trauma history of the individual's associated group.

This allows gathering information regarding the distinct responses between groups, which can give insight into the differences in how historical trauma is manifested and eventually be utilized in customizing interventions across communities. In this way, the IPS can be used to identify trends in symptoms and behaviors in individuals who are affected by historical trauma while simultaneously respecting the diversity of experiences between indigenous groups. Before it can be utilized, this measure must be reviewed, modified, and approved by a panel. Once finalized, however, the IPS will be a particularly useful tool in quantifying historical trauma as well as determining effectiveness of various interventions.

4. Adverse Childhood Experiences (ACEs)

As historical trauma influences multiple generations, the impact of adverse childhood experiences (ACEs) on the health of Native American populations is an important issue to consider and can possibly be viewed as an indication of historical trauma. Galos[11] declares that the multidimensional impact of maltreatment confirms the outcomes of a previous ACE Study conducted by the Center for Disease Control, which suggests that the effects of experiencing multiple adverse events in childhood have additive effects.

These additive effects in native communities are demonstrated in the report of ACEs in Minnesota by Baum and Peterson-Hickey[1], who state that 27% of Native Americans report high (five or more) ACE scores, whereas only 7% was reported in the white population in 2011. The indication of historical trauma in the form of ACEs is also shown in a study done by Myhra and Wieling[13], who investigated the effects of historical trauma and its relation to substance abuse across generations of indigenous families. The reported experiences met most of the previously described ACE conditions, and include sexual abuse, physical abuse, neglect, loss of family members and friends, violence in the family and community, substance abuse in the household, and the effect of mental health issues in family members. Effects of boarding schools in families, as well as contemporary experiences with discrimination and racism, were also discussed. Myhra and Wieling[13] learned that although the second generation experienced a fewer number of traumatic experiences than the first, this amount remains to be significantly greater than the those in other racial groups.

Race-based differences in the prevalence of ACEs and child behaviors were examined in a study by Kenney and Singh[12] between American Indian and Alaska Native (AI/AN) children and Non-Hispanic White (NHW) children. Results of this indicated that AI/AN children are twice as likely to experience more than three ACEs, and three times as likely to experience more than five ACEs when compared to NHW children. In AI/AN children, ACEs had a greater impact on reported behavior as well. For children experiencing more than 3 ACEs, issues in school and failing grades were also more than twice as likely in AI/AN children as compared to their NHW counterparts. While these disparities are extensively documented and well known, they are not truly addressed in the clinical setting.

5. Barriers to Treating Historical Trauma

One barrier to clinical treatment of historical trauma is that there is a lack of a formal diagnosis. Evans-Campbell[9] discusses how the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) the manual that clinical practitioners use to diagnose and treat psychological issues, does not adequately address trauma. She also states that the classifications of disorders in DSM-5 is limited by its focus on individual symptoms and thus cannot adequately be used to understand health in native communities. While disorders such as Post-Traumatic Stress Disorder (PTSD) may include most of the symptoms that those affected by historical trauma, Evans-Campbell writes that it fails to fully capture the full effects of the intergenerational experiences of this trauma and the interaction of historical and contemporary traumas.

The DSM-5 is also criticized by Van der Kolk[15] in his book, where he discusses how cultural healing is not recognized and, since it is not a billable service, is less likely to be addressed let alone treated in the clinical setting. This leads to another issue with clinical treatment - cultural competency. Brave Heart et al.[3] express their concern for culturally competent providers in communities affected by historical trauma. A helpful guide to educate practitioners is provided by Duran et al.[6], who writes about using indigenous perspectives in practice while working with native communities. An overview of historical trauma and oppression as well as issues that these communities face today is discussed as well as information for those who are non-native about indigenous cultural beliefs and the history that has led to the trauma that is experienced in these communities.

6. Interventions for Historical Trauma

To learn about the interventions currently used in local communities, I reached out to Linda Eagle Speaker[7], who is a seventh-generation Blackfoot herbalist and current Elder in Residence at the Minnesota Indian Women's Resource Center in Minneapolis. She started working as a social worker in Minneapolis after moving from Alberta, Canada and later became the director of the Sacred Journey program in Minneapolis, which aims to support adult women in the Native American community with mental health, substance abuse, and trauma.

With Donna La Chapelle, an Anishinaabe elder, Eagle Speaker worked with women to overcome substance abuse. For those with children in child protection, Eagle Speaker and La Chapelle would ensure that they were placed in a good home. In the meantime, they would help the mother overcome chemical dependency. This included establishing connections to the community and bringing them to sweat lodges and other traditional ceremonies. After about four or six months, however, women would not simply relapse, but completely abandon everything that they strenuously worked for - they would lose their home, lose custody of their children once again, and detach

themselves from the community. This pattern was seen for almost all their clients, and Eagle Speaker and La Chapelle struggled to determine how to connect the mental state of their clients with their spiritual self.

Meanwhile, a group of Lakota elders were traveling to several major cities from Pine Ridge to Washington D.C. to speak out against the ongoing genocide of the Lakota people and screen their documentary "Red Cry". While attending their event in Minneapolis, La Chapelle met Dr. Kathy Farah, a family and integrative medicine physician who is certified in mind-body medicine. Mind-body medicine is a holistic approach to healing that emphasizes the interconnection of the mind, the body, and the spirit. La Chapelle invited Dr. Farah to the Minnesota Indian Resource Center to demonstrate the mind-body medicine methods and techniques to Eagle Speaker and their staff. Dr. Farah was trained at the Center for Mind-Body Medicine (CMBM), which is a non-profit organization located in Washington D.C. that provides the largest program in the world to train others in mind-body medicine techniques. Their model focuses on promoting self-expression and awareness by using self-regulation techniques in the context of small group support.

After these sessions with Dr. Farah, Eagle Speaker as well as the other staff were pleasantly surprised by the positive results that they experienced. All of them were initially under a considerable amount of stress, and subsequently found themselves to be more relaxed, concentrated, and productive while using these techniques. Eagle Speaker and La Chapelle went to Suzanne Koepplinger, the executive director of the center at the time, and told her their interests in being trained in this so that they can heal their clients. The CMBM provides several training curricula that differ in levels of qualification: The Professional Training Program in Mind-Body Medicine, Advanced Mind-Body Medicine Training, and the Certification in Mind-Body Medicine. The Professional Training Program is the most common program that people enroll in. This entails training over the course of five days to gain a comprehensive understanding in the theory and application of the mind-body medicine techniques. This program aims to prepare professionals to integrate these techniques into their daily lives as well as in their clinical practice.

A distinctive feature of the model created by the Center for Mind-Body Medicine is that it directly addresses trauma that impacts entire communities. The CMBM works with various populations around the globe, including the Palestinian population in Gaza. In 2002, the founder and director of the Center for Mind-Body Medicine, James Gordon, began working in Gaza to determine if the CMBM model could successfully reduce stress and promote health in severely traumatized populations. It's not a surprise that Gordon selected Gaza to test this theory, as this population experiences tremendous amounts of stress and trauma due to colonization, war, and human rights violations. In fact, the Center for Mind-Body Medicine's work in Gaza became the basis of the largest program in the world that focuses on population-wide trauma.

A vital quality of the program offered by the Center for Mind-Body Medicine is that there is an underlying understanding that people in these communities already contain knowledge for healing. Their model is designed to allow the community to integrate these basic techniques into their own cultural healing traditions and ceremonies. This is critical, as it promotes healing within the community as opposed to governing actions in the community as an outside force. The group work that is involved in this model also efficiently treats individuals while surrounded by other members of the community in a supportive environment. This differs from the focus prescribed by the previously mentioned DSM-5 on individual symptoms. According to the World Health Organization[17], over 20% of the population have mental health issues. The prevalence of post-traumatic stress disorder (PTSD) is also remarkably high, particularly in children and adolescents.

Furthermore, since this approach entails people in the community to be involved in healing others, cultural competency no longer poses an issue. This model is also well-suited for those in communities in which mental health professionals are not easily accessible or too expensive, since certifications and degrees are not required to be trained in the program. There are now over a thousand clinicians, educators, and community leaders trained in mind-body medicine techniques. As opposed to the prescription of drugs–one of the most common methods used in treating psychological issues–the self-regulating techniques can be employed both in and out of the treatment setting. Thus, these seemingly simple techniques help individuals cope with stress in efforts of impeding the development of psychological issues in addition to treatment. In 2011, the Center for Mind-Body Medicine stated that in Gaza, 90% of children diagnosed with PTSD stated that they no longer reported symptoms after 10 weeks of group meetings.

After their first training session, Eagle Speaker and La Chapelle were qualified to conduct their first group session with women in the treatment program. Several of the techniques taught by the CMBM are particularly useful to help people heal from trauma, and include soft belly breathing, guided imagery, drawing, and shaking and dancing. Soft belly breathing involves slow and regulated deep breathing. In the Center for Mind-Body Medicine's model, this technique is used to begin every treatment session to relax, and participants are encouraged to use this in their own lives to release tension and increase concentration. By activating the Vagus nerve, this exercise allows the body to decrease heart rate and blood pressure. The activation of the parasympathetic nervous system also inhibits the

amygdala, which is a region in the brain that is implicated in fear and anger. Simultaneously, activity increases in the frontal cortex which is the area of the brain involved in judgement and self-awareness.

This is particularly helpful for those who have experienced trauma, as their body tends to be in a continuously tense state. This exercise physiologically reduces stress and increases a sense of wellbeing, which allows the individual to feel more comfortable in the healing process. Eagle Speaker frequently employs the soft belly breathing technique with children to assist them in becoming more comfortable with talking about past trauma. She regularly works with highly traumatized young women, who have experienced abuse and sex trafficking. One incident that she mentioned in our conversation involved a young girl who was a victim of sex trafficking. She was referred to Eagle Speaker because she refused to talk to anyone about her experiences, likely due to mistrust of law enforcement. By using mind-body techniques, the young girl was able to develop a trusting relationship and disclose her painful experiences. This allowed the child to testify her experiences in court against her perpetrator, which substantially contributed to charging the perpetrator with one of the longest sentences ever given in Minnesota for sex trafficking.

Another useful mind-medicine technique is guided imagery, which involves visualizing mental images, as well as drawing techniques are utilized in order to explore and solve emotional and mental issues. Eagle Speaker used this technique at the beginning and at the end of the program to track her clients' progress. On the first day, the women were instructed to draw a set of photos including themselves, their problem and their solutions at the beginning and the end of the session. Eagle Speaker remembered one woman in particular, who had been struggling with alcohol abuse and drew herself in a box to represent no escape from her problem. She did not have a home, family or friends for support. In her set of drawings at the end of the session, the box was no longer closed and a small heart was drawn just outside the opening. The woman told her that during this session was the first time in many years that she felt encouraged and saw a chance of recovering. Throughout the program, Eagle Speaker saw her drawings continually improve. She noticed increased attendance rates of the women in the first few weeks as well as increased recovery rates later on.

These immediate results in the clinic motivated Eagle Speaker and La Chapelle to continue in the Advanced Training program, which is next level of training that takes about two years to complete. Koepplinger was able to obtain a grant for this and became their benefactor. This involves at least 32 hours of practice with leading groups under the supervision of a Center for Mind-Body Medicine faculty member, to which Dr. Farah readily filled the role. Those who complete Advanced Training will also learn how to lead their own groups in accordance with the company's mind-body skills group model. Once completed, these techniques can then be employed to work with individuals and families in addition to groups, and applied in educational settings.

To further progress in training, Eagle Speaker and La Chapelle took a practicum under the supervision of Dr. Farah before entering the Certification program. While acquiring this certification, Eagle Speaker conducted her own 10-week group with women at the treatment center. This training aims to teach the theory of mind-body medicine as well as how to incorporate mind-body medicine techniques in daily life and clinical practice, including healthy eating and basic nutrition, and the psychological dimensions of chronic illness. Those who are certified are also able to identify situations in which medical conditions would prevent these techniques from safely being used.

After this program was completed, Eagle Speaker and La Chapelle were qualified to integrate the mind-body medicine model into their own communities and institutions as well as create their own applications of the model. Both Eagle Speaker and La Chapelle wanted to bring these experiences to Native American communities all over Minnesota. Although Eagle Speaker did not mention this during our conversation, another program that may be potentially helpful from the Center for Mind-Body Medicine is the Food as Medicine Professional Training program, which is aimed towards educating nutritionists and health professionals. This provides information on how to integrate nutrition into clinical practice in order to treat chronic diseases in patients.

This is especially important in Native American communities, as the Center for Disease Control[5] reported that 42.3% of adults in Native Americans communities were obese in 2014. Inadequate nutrition leads to the development of numerous health issues including type 2 diabetes, obesity, and cardiovascular disease. In discussing this it is important to mention that an extremely large portion of Native American reservations are located in a food desert, which is described as an area lacking at least one grocery store for every ten miles[8]. Without access to nutritional food, nutritional education alone will not lead to a significant improvement. However, as it contributes to health disparities in conjunction with historical trauma, nutritional education would be beneficial nevertheless.

Eagle Speaker and La Chapelle traveled to all 11 of the federally-recognized tribes in the state of Minnesota to promote awareness of mind-body medicine and help them receive seed grants to pay for people in those communities to undergo training. The Center for Mind-Body Medicine trains not only healthcare providers, but educators and community leaders as well. For those who cannot afford training, financial scholarships are provided to individuals who work with underserved communities, military, veterans, or children in crisis situations. Within all

the federally-recognized tribes that Eagle Speaker and La Chapelle visited, there are approximately four to eight people that are currently being trained in mind-body medicine. In Minnesota, there are now a total of 26 people that practice mind-body medicine in healing others in their own communities. In 2014, Eagle Speaker and La Chapelle started going to Pine Ridge to conduct mind-body medicine workshops to combat the youth suicide epidemic, and have seen positive results so far.

The CMBM is also working with leaders in Native American communities in Minnesota and South Dakota to develop a program geared towards historical trauma to be used nationwide. Considering the context in which historical trauma emerged, it becomes clear why the Western medical model has not proven to be successful; the direction of treatment is misplaced. This is not to suggest that individuals should not be treated, as they are certainly affected by historical trauma–this is illustrated by the manifestations of historical trauma as anxiety, depression, and suicide. Through ACEs and intergenerational abuse, families are impacted as well. Ultimately, the prevalence of these health conditions and social issues are substantially widespread in Native American communities. As such, it is imperative to address historical trauma in treatments specifically directed towards these communities.

7. Acknowledgements

The author wishes to express her utmost appreciation and gratitude to Dr. Carter Meland for his continual guidance and encouragement throughout the writing of this thesis, as well as Mrs. Eagle Speaker for her time and significant contributions to this project.

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